CENTERSTON	WEDICARE & WEDIC	- SERVICES			0.11	B 110.0200 0021
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPL	ETED
		155526	A. BUILDING		06/24/2	011
		100020	B. WING			011
NAME OF D	ROVIDER OR SUPPLIEI	D.	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI ELEI	ix.	1 200	N PARK ST		
PERSIMI	MON RIDGE REHA	ABILITATION CENTRE	POR	TLAND, IN47371		
710 TD	avn a conve					77.5
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE OPRIATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
F0000						
	This visit was fo	or the Investigation of	F0000	i		
		_	10000			
	Complaint IN00	092008.				
	Complaint IN00	092668 - Substantiated.	1			
	Federal/state det	ficiencies related to the	1			
		ited at F157, F224, F225,	1			
	_	ited at F137, F224, F223,				
	F226, F490.					
	Survey date: Ju	ne 24 2011				
	Sarvey date. van	10 2 1, 2011				
		000110				
	Facility number:	: 000148				
	Provider number	r: 155526				
	AIM number: 1	00275500				
	THE HAIR OF T	00278800				
	Surveyor: Rand	all Fry RN				
	Census bed type					
	SNF/NF: 85	·•				
	Total: 85					
			1			
	Census payor ty	pe:	1			
	Medicaid: 61	1				
			1			
	Medicare: 6		1			
	Other: 18					
	Total: 85		1			
	Campala 2		1			
	Sample: 3					
			1			
	These deficienci	ies also reflect state	1			
		rdance with 410 IAC 16.2.	1			
	inidings in accor	10 1AC 10.2.	1			
			1			
	Ouality review 6	5/28/11 by Suzanne				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W8QP11

Facility ID:

000148

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	A. BUII	LDING	OO	(X3) DATE S COMPL 06/24/2	ETED
			B. WIN		DDDEGG GITY GTATE GID CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	ODRESS, CITY, STATE, ZIP CODE		
PERSIM	MON RIDGE REHA	BILITATION CENTRE		200 N PA PORTLA	ND, IN47371		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E .	DATE
	Williams, RN						
F0157 SS=D	A facility must immoresident; consult wand if known, notification of the presentative or a when there is an a resident which responsible potential for requiring significant change mental, or psychosocial status conditions or clinical alter treatment significant change mental, or psychosocial status conditions or clinical treatment significant reatment significant change in resident and, if known as specified. The facility must a resident and, if known representative or in when there is a change in resident as special change in resident state law or regular paragraph (b)(1) of the facility must resident's legal regramily member. Based on recording facility failed to contified of a charter sidents reviewed.	is in either life threatening cal complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the lown, the resident's legal interested family member lange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or ations as specified in of this section. Becord and periodically is and phone number of the presentative or interested review and interview, the ensure the physician was age in condition for 1 of 3 and for physician	F0	157	1. The physician for Resider was updated on June 17, 20 regarding the resident's condition. 2. All other resident have the potential to be affect.	11 its ited.	07/08/2011
	notification in a s	sample of 3 (resident A).			The clinical records have bee reviewed for all residents, an change of condition was note	d if a	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	W8QP11	Facility II	D: 000148 If continuation sh	neet Pag	ge 2 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155526	B. WIN			06/24/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	(200 N F	PARK ST		
		BILITATION CENTRE			AND, IN47371		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
IAG	1	·	+	IAG	, ,	4:CI	DATE
TAG	Review of the cl A on 6/24/11 at 1 resident was adm 9/20/10. Resider including, but no schizophrenia, at A history and phindicated the resulcohol abuse. Review of the cl A on 6/24/11 at 1 following nursin "6/16/11 at 10:30 from LOA (leave wheel chair with liters per minute Portable 02 tank CNA took reside bed." "6/16/11 at 11:00 resident's room be 1'm so sorry. Reliquid with black blouse, front of spuddle on floor. and CNA repeate you are so beaut with removing classisted to bed.	inical record for resident 1:00 PM, indicated the nitted to the facility on nt A had diagnoses' of limited to: paranoid nxiety, and depression. ysical exam dated 9/7/10 ident had a history of inical record for resident 1:00 PM, included the		TAG	the primary physician was not as indicated.3. The facility's policy for Physician Notification (See Attachment has been reviewed and not changes are indicated at this time. The nurses have been re-educated on physician notification related to change condition. (See Attachment nurses notes review form habeen initiated to ensure physiciation is done (See Attachment C).4. The DON designee will review nurses five days per week on sched work days for all residents are will complete the nurses note review form for a minimum of months. Results of these review form for a minimum of months. Results of these review form for a during the facility's quarterly QA meetin and the plan adjusted accordingly. 5. The above corrective actions will be completed on or before July 2011.	otified A) of B). A s sician or notes uled nd es f 6 views	DATE
		drinksresident has no					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526		(X2) MUI A. BUILD B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/24/20	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	! }			DDRESS, CITY, STATE, ZIP CODE		
PERSIM	MON RIDGE REHA	BILITATION CENTRE		200 N PA	AND, IN47371		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	Pleasant, smiling "6/17/11 at 2:00 bed in supine po bed) elevated, re unlabored." "6/17/11 at 9:00 75% and 480 cc breakfast withou emesis noted, sta "6/17/11 at 10:4: aware of previou orders at this tim. The clinical reco have documenta notified of this re to 6/17/11 at 10: The clinical reco have documenta to consume alco 6/17/11. An interview wi Nursing and the Consultant, on 6 indicated there we physician was not 10:45 AM.	ord for resident A did not tion the physician was esident's condition prior					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL		
THEFTERN	or condition	155526	A. BUIL			06/24/2	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	00/2 //	
NAME OF I	PROVIDER OR SUPPLIER				PARK ST		
PERSIMI	MON RIDGE REHAI	BILITATION CENTRE			AND, IN47371		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0224 SS=D	The facility must de written policies and mistreatment, negland misappropriate Based on record facility failed to de reviewed for abus sample of 3, was staff (resident A) Findings include: Review of the cli A on 6/24/11 at 1 resident was adm 9/20/10. Resider including, but no schizophrenia, and A history and phy indicated the resident alcohol abuse. Review of a facil 6/17/11 on 6/24/11 the following: ". 6/16/11 involving facility Administration."	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. The review and interview, the ensure 1 of 3 residents se/mistreatment in a not mistreated by facility	F0:	224	1. Resident A is her own responsible party and signed of the facility to go to a bar to celebrate her birthday with the Administrator and Activity Director. Upon return to the facility, Resident A experience an emesis episode. Resider was cleaned up, assisted to and safety was ensured. The Administrator and Activity Director. Administrator and Activity Director. All residents have the potential affected. See below for corresponding to the facility's perfor Abuse (Mistreatment) has been reviewed and no change are indicated at this time (See Attachment D). The facility's including the new Administration and Activity Director, have be re-educated on abuse and mistreatment (See Attachment E). An Abuse Monitoring for (See Attachment F) has been intiatied to ensure abuse/mistreatment does no occur.4. The Administrator of designee will complete the A	eed eed eet A bed, ee rector other to be ective oblicy s ges e staff, tor een nt m n	07/08/2011
	Activity Director	took (resident A) to a 2011 per (resident A)			Monitoring form daily on scheduled work days for a minimum of 6 months. The Regional Director and/or Nur	rse	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA							3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155526	B. WIN	IG		06/24/2	011	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	PARK ST			
PERSIMI	MON RIDGE REHA	BILITATION CENTRE		PORTL	AND, IN47371			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	\	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	Consultant will review this fo	rm at	DATE	
	_	oirthday. (Resident A)			least twice monthly for two	IIII at		
	-	at at 6:00 PM, and was			months, then monthly for at I	•		
	1 ~	the facility at 10:30			4 months. Results of these			
		atement: "(Resident A)			reviews will be discussed du	ring		
		l a good time. Said she			the facility's quarterly QA meetings and the plan adjus	ted		
		ey and cokes and some licated the other drinks			accordingly.5. The above			
					corrective actions will be	_		
		gin in them as that			completed on or before July 2011.	8,		
	1 1	1. Indicated she drank 8-9			2011.			
	drinks for her bir	inday.						
	Review of the nu	ursing notes for resident A						
	included the follo	•						
) PM: Resident returned						
		e of absence). Resident in						
	`	02 (oxygen) on at two						
		via nasal cannula.						
	_	on back of wheel chair.						
		nt to room to assist to						
	bed."	iii to room to assist to						
		PM: Summoned to						
		by CNA. Resident states						
		sident had vomited clear						
	1	flecks. Emesis covers						
	1 ^	lacks and is in a large						
		Resident looks at writer						
	_	edly stating I love you,						
	_	ful. Assisted resident						
	1 ~	lothes. Put gown on						
	1	Side rail up and call light						
		esident again states I'm so						
		drinksresident has no						
	complaints of pa							
	1 -	g and smells of alcohol."						
	1 - 10000011, 5111111112	, 5 51 41001101.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
		155526	A. BUI B. WIN			06/24/2	011
NAME OF I	DROWINED OR CLINDLIED		D. WII		ADDRESS, CITY, STATE, ZIP CODE	Į.	
	PROVIDER OR SUPPLIER			1	PARK ST		
PERSIMI	MON RIDGE REHA	BILITATION CENTRE		PORTL	AND, IN47371		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		AM: Resident resting in	-	IAU			DATE
		sition. HOB (head of					
		spirations 18, even and					
	unlabored."	spirations 10, even and					
	"6/17/11 at 9:00.	AM: Resident consumed					
	75% and 480 cc	(cubic centimeters) of					
	breakfast withou	t any difficulty, no					
	emesis noted, sta	tes I'm just a little tired."					
		5 AM: (Physician) made					
		s outing with no new					
	orders at this tim						
		PM: Telephone order					
		ysician). May have					
		ges in moderation PRN					
	(as necessary)"						
	A physician's ord	ler dated 6/20/11					
		ontinue order may					
	consume alcohol	•					
	moderation PRN	. Resident may consume					
	two alcoholic be	verages daily PRN."					
		rd for resident A did not					
		ion of a physician's order					
	to consume alcorulation for the following th	nolic beverages prior to					
	0/1//11.						
	An interview wit	h the facility Regional					
		ations on 6/24/11 at					
	12:50 PM, indica						
	Director's employ	-					
		this incident, and the					
	facility Administ	rator was currently on					
	administrative le	ave pending a decision					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/24/2011
	PROVIDER OR SUPPLIER	BILITATION CENTRE	STREET A	ADDRESS, CITY, STATE, ZIP CODE PARK ST AND, IN47371	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	incident. The R Operations indicand oriented, was not have a Power Care Representat	y action regarding this egional Director of ated the resident was alert is her own person, and did of Attorney or Health tive. Is related to complaint			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155526	B. WING			06/24/2	011
			P. 11211		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ARK ST		
PERSIMI	MON RIDGE REHA	BILITATION CENTRE			AND, IN47371		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0225 SS=D	have been found of or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to de registry or licensing					
	The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).						
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the adding representative and accordance with S State survey and oworking days of the violation is verified action must be take				4. The incident involving		
	facility failed to involving mistrea Indiana State De	review and interview, the report an incident atment of a resident to the partment of Health and accordance with state	F02	225	The incident involving Resident A was reviewed wit the legal department and per discussion, felt it did not mee ISDH reportable guidelines (Attachment G). The facility h	et the See	07/08/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W8QP11 Facility ID:

000148

If continuation sheet

Page 9 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155526	B. WIN			06/24/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			200 N F	PARK ST		
	MON RIDGE REHA	BILITATION CENTRE		PORTL	AND, IN47371		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		N
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG		DATE	
		idents reviewed for			reported the incident to the F board (See Attachment H), a	I	
		nistreatment in a sample			per the state surveyor's	ilu	
	of 3. (Resident A	A).			recommendations, the facility	has	
					also reported the incident to		
	Findings include	:			on June 30, 2011.2. All incid	I	
					have been reviewed, and if the meet the ISDH reportable	ney	
	Review of the cli	nical record for resident			guidelines, have been report	ed to	
	A on 6/24/11 at 1	:00 PM, indicated the			ISDH and other officials in		
	resident was adm	nitted to the facility on			accordance with state law.3.	The	
	9/20/10. Resider	nt A had diagnoses			facility's policy for reporting		
		t limited to: paranoid			incidents to ISDH has been		
		nxiety, and depression.			reviewed and no changes are indicated at this time (See		
		ysical exam dated 9/7/10			Attachment I). The DON and	ı	
		dent had a history of			new Administrator have		
	alcohol abuse.	dent nad a mistory of			been educated on the report		
	arconor abuse.				guidelines (See Attachment		
	Davious of a facil	ity incident report dated			An Abuse Monioring form (So Attachment E) has been initial	I	
		•			to ensure incidents are repor	I	
		11 at 12:05 PM, included			per policy.4. The Administra	I	
	I	Incident occurring on			designee will complete the a	ouse	
		g (resident A), (The			monitoring form daily on		
	*	rator), and (the Activity			scheduled work days for a minimum of 6 months. The		
	/ \	dministrator and the			Regional Director and/or Nur	se	
	· -	t) took (resident A) to a			Consultant will review this for		
	l '	2011 per (resident A)			least twice monthly for two		
	_	irthday. (Resident A)			months, then monthly for at I		
	~	t at 6:00 PM, and was			4 months. These reviews will discussed during the facility's	pe	
	brought back to t	he facility at 10:30			quarterly QA meetings and the	ne	
	PMResident sta	atement: "(Resident A)			plan adjusted accordingly.5.		
	indicated she had	l a good time. Said she			above corrective actions will	be	
	drank five whisk	ey and cokes and some			completed on or before July	3,	
	other drinks. Indicated the other drinks				2011.		
	had to have slow	gin in them as that					
		Indicated she drank 8-9					
	drinks for her bir						

000148

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155526	B. WIN			06/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					PARK ST		
PERSIM	MON RIDGE REHA	BILITATION CENTRE		PORTL	AND, IN47371		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		arsing notes for resident A					
	included the foll	•					
		OPM: Resident returned					
	`	e of absence). Resident in					
	wheel chair with	02 (oxygen) on at two					
		via nasal cannula.					
	Portable 02 tank	on back of wheel chair.					
	CNA took reside	ent to room to assist to					
	bed."						
	"6/16/11 at 11:00	PM: Summoned to					
	resident's room b	by CNA. Resident states					
	I'm so sorry. Re	sident had vomited clear					
	I -	flecks. Emesis covers					
	1 -	slacks and is in a large					
		Resident looks at writer					
	_	edly stating I love you,					
	1 ^	iful. Assisted resident					
	l *	lothes. Put gown on					
	1	Side rail up and call light					
		esident again states I'm so					
		drinksresident has no					
	1 -	in or discomfort.					
	1 ^ ^	g and smells of alcohol."					
		AM: Resident resting in					
		sition. HOB (head of					
		spirations 18, even and					
	unlabored."	spirations 10, even and					
		AM: Resident consumed					
		(cubic centimeters) of					
		· /					
		t any difficulty, no					
		ates I'm just a little tired."					
		5 AM: (Physician) made					
	aware of previou	is outing with no new					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE SURVE COMPLETED	EY	
		155526	B. WIN			06/24/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PERSIMI	MON RIDGE REHA	BILITATION CENTRE		1	PARK ST AND, IN47371		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CON	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	IPLETION DATE
	orders at this tim	e."					
		PM: Telephone order					
		ysician). May have					
		ges in moderation PRN					
	(as necessary)"						
	A physician's ord	ler dated 6/20/11					
		ontinue order may					
	consume alcohol	•					
		. Resident may consume					
	two alcoholic be	verages daily PRN."					
	The clinical reco	rd for resident A did not					
		tion of a physician's order					
	to consume alcol	nolic beverages prior to					
	6/17/11.						
	An interview wit	h the facility Regional					
		ations on 6/24/11 at					
	,	ated the facility had not					
	_	dent because the facility					
	_	ised them this incident					
	agency; however	eporting to any state					
	J 27	ide a summary of this					
		diana Health Facility					
	Administrators E	-					
	This deficiency i IN00092668.	s related to complaint					
	111100092668.						
	3.1-28(c)						
	3.1-28(e)						

000148

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING 00 COMPLETI B. WING 06/24/201			ETED		
NAME OF PROVIDER OR SUPPLIER PERSIMMON RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN47371				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0226 SS=D	written policies and mistreatment, negland misappropriate Based on record facility failed to procedure for repinvolving mistreat Indiana State Depother officials in law for 1 of 3 restreporting abuse/rof 3. (Resident A Findings include Review of a facil 6/17/11 on 6/24/1 the following: ". 6/16/11 involving facility Administ Director). (The A Activity Director baron June 16, request for her b signed herself ou brought back to the PMResident statindicated she had drank five whisk other drinks. Indihad to have slow	,	F0	226	1. The incident involving Res A was reviewed with the legal department and per discussifelt it did not meet the ISDH reportable guidelines (See Attachment G). The facility hereported the incident to the Hoard (See Attachment H) and per the state surveyor's recommendations, the facility also reported the incident to on June 30, 2011.2. All incident have been reviewed, and if the meet the ISDH reportable guidelines, have been report ISDH and other officials in accordance with state law.3. facility's policy for reporting incidents to ISDH has been reviewed and no changes and indicated at this time (See Attachment I). The DON and Administrator have been educated on the reporting guidelines (See Attachment E) has been initiate to ensure incidents are reporting per policy. The Regional Direct and/or Nurse Consultant will review this form at least twice monthly for two months, ther monthly for at least 4 months. The Administrator or designed complete the abuse monitoring form daily on scheduled world days for a minimum of 6 more	al oon, as as as a second of the second of t	07/08/2011

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
		155526	B. WING 06/24/2011				
NAME OF PR	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NUMBER OF TROVIDER OR SOTTELER				I	PARK ST		
PERSIMM	ION RIDGE REHAI	BILITATION CENTRE		PORTL	AND, IN47371		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	drinks for her bir	thday."			The Regional Director and/or Nurse Consultant will review		
					form at least twice monthly for	- I	
		esident A was reviewed			two months, then monthly for	- I	
		0 PM. Review of the			least 4 months. These review	vs	
I .		resident A included the			will be discussed during the	aa	
I .	following:				facility's quarterly QA meeting and the plan adjusted	ys	
		PM: Resident returned			accordingly.5. The above		
I .		of absence). Resident in			corrective actions will be		
I .	1			completed on or before July	8,		
I .	•	via nasal cannula.			2011.		
	Portable 02 tank on back of wheel chair.						
I .		nt to room to assist to					
	bed."						
	"6/16/11 at 11:00	PM: Summoned to					
	resident's room b	y CNA. Resident states					
	I'm so sorry. Res	sident had vomited clear					
	liquid with black	flecks. Emesis covers					
	blouse, front of s	lacks and is in a large					
	puddle on floor.	Resident looks at writer					
	and CNA repeate	edly stating I love you,					
	you are so beauti	ful. Assisted resident					
	with removing cl	othes. Put gown on					
		Side rail up and call light					
	within reach. Re	sident again states I'm so					
	sorry I had some	drinksresident has no					
	complaints of pai	in or discomfort.					
	Pleasant, smiling	and smells of alcohol."					
	"6/17/11 at 2:00 A	AM: Resident resting in					
I .		sition. HOB (head of					
	bed) elevated, respirations 18, even and						
	unlabored."						
	"6/17/11 at 9:00 A	AM: Resident consumed					
	75% and 480 cc ((cubic centimeters) of					
I .		t any difficulty, no					

000148

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155526			A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/24/2	ETED
100020			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/24/2	011
NAME OF PROVIDER OR SUPPLIER					PARK ST		
PERSIMMON RIDGE REHABILITATION CENTRE				1	AND, IN47371		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORREPTIX (EACH CORRECTIVE ACTION SHO			
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE	
TAG	emesis noted, sta "6/17/11 at 10:45 aware of previous orders at this time "6/17/11 at 12:30 received per (phy alcoholic beverag (as necessary)" A physician's ord included: "Disco- consume alcoholic moderation PRN two alcoholic beverag to consume alcoholic beverag to consum	tes I'm just a little tired." AM: (Physician) made s outing with no new e." PM: Telephone order vsician). May have ges in moderation PRN der dated 6/20/11 ontinue order may ic beverages in . Resident may consume verages daily PRN." rd for resident A did not ion of a physician's order nolic beverages prior to rrent facility policy and use prohibition, vestigation dated 1/06, the Director of Nursing 0 PM, included, but was following: "2. ort all unusual		TAG			DATE
	occurrences, which includes abuse, within 24 hours of discovery, to the Long Term						
	Care Division of	_					
	Department of H	ealth"					
		h the facility Regional ations on 6/24/11 at					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W8QP11 Facility ID:

000148

If continuation sheet

Page 15 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/24/2011
NAME OF PROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	
PERSIMI	MON RIDGE REHA	BILITATION CENTRE		PARK ST LAND, IN47371	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	12:50 PM, indicated the facility had not reported this incident because the facility attorney had advised them this incident did not require reporting to any state agency; however; the facility was planning to provide a summary of this incident to the Indiana Health Facility Administrators Board. This deficiency is related to complaint IN00092668. 3.1-28(a)				
F0490 SS=D	that enables it to use and efficiently to a practicable physical well-being of each Based on record facility failed to describe a facility failed to describe and the facility A Findings include Review of the clip A on 6/24/11 at 1 resident was admit 9/20/10. Resident	review and interview, the ensure 1 of 3 residents treatment by staff in a dent A), was not a facility Administrator activity Director.	F0490	1. Resident A is her own responsible party and signed of the facility to go to a bar to celebrate her birthday with the Administrator and Activity Director. Upon return to the facility, Resident A experience an emesis episode. Residen was cleaned up, assisted to and safety was ensured. The Administrator and Activity Director and	ced t A bed, e rector new rector to be ective

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W8QP11 Facility ID: 000148

If continuation sheet

Page 16 of 19

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED	
155526		155526	B. WIN			06/24/20	11
		l .	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			PARK ST		
PERSIMI	MON RIDGE REHA	BILITATION CENTRE			AND, IN47371		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	schizophrenia, a	nxiety, and depression.			for Abuse (Mistreatment) has		
	A history and ph	ysical exam dated 9/7/10			been reviewed and no chang	· .	
		ident had a history of			are indicated at this time (Se		
	alcohol abuse.	- 			Attachment D). The facility s including the new Administra		
	areonor doube.				and Activity Director, have be		
	Daviou of a faci	lity incident report dated			re-educated on abuse and		
		•			mistreatment (See Attachme	ent E).	
		11 at 12:05 PM, included			An Abuse Monitoring form (S		
	· ·	Incident occurring on			Attachment F) has been intia		
		g (resident A), (the			to ensure abuse/mistreatment does not occur. The Regiona		
	· ·	trator), and (the Activity			Director and/or Nurse Consu		
	, ` `	Administrator and the			will review this form at least		
	l *	r) took (resident A) to a			monthly for two months, ther		
	baron June 16,	2011 per (resident A)			monthly for at least 4 months		
	request for her b	oirthday. (Resident A)			The Administrator or designe complete the Abuse Monitori		
	signed herself or	at at 6:00 PM, and was			form daily on scheduled wor	~ 1	
	brought back to	the facility at 10:30		days for a minimum			
	PMResident st	atement: "(Resident A)			The Regional Director and/o		
	indicated she had	d a good time. Said she			Nurse Consultant will review		
	drank five whisk	rey and cokes and some			form at least twice monthly fo two months, then monthly fo		
	other drinks. Inc	dicated the other drinks			least 4 months. Results of th		
	had to have slow	gin in them as that			reviews will be discussed du	ring	
	sneaks up on you	u. Indicated she drank 8-9			the facility's quarterly QA		
	drinks for her bi				meetings and the plan adjus	ted	
		_			accordingly.5. The above corrective actions will be		
	Review of the m	ursing notes for resident A			completed on or before July	8,	
	included the foll	C			2011.	·	
		0 PM: Resident returned					
		e of absence). Resident in					
	wheel chair with 02 (oxygen) on at two liters per minute via nasal cannula. Portable 02 tank on back of wheel chair.						
		ent to room to assist to					
	bed."	12 100111 10 455151 10					
		O PM: Summoned to					
	5/15/11 at 11.00	o i i i					

l i i i i i i i i i i i i i i i i i i i		DENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
			A. BUI B. WIN			06/24/2		
					ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF PROVIDER OR SUPPLIER				1	PARK ST			
PERSIMMON RIDGE REHABILITATION CENTRE				PORTL	AND, IN47371			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAG		by CNA. Resident states	+	IAG			DATE	
		sident had vomited clear						
	1	flecks. Emesis covers						
	1 -	lacks and is in a large						
		Resident looks at writer						
	1 ^	edly stating I love you,						
		ful. Assisted resident						
	l *	othes. Put gown on						
		Side rail up and call light						
		esident again states I'm so						
	sorry I had some	drinksresident has no						
	complaints of pain or discomfort. Pleasant, smiling and smells of alcohol."							
	"6/17/11 at 2:00 .	AM: Resident resting in						
	bed in supine pos	sition. HOB (head of						
	bed) elevated, res	spirations 18, even and						
	unlabored."							
		AM: Resident consumed						
		(cubic centimeters) of						
		t any difficulty, no						
	l '	tes I'm just a little tired."						
		AM: (Physician) made						
	1	s outing with no new						
	orders at this time							
		PM: Telephone order						
		ysician). May have						
	l -	ges in moderation PRN						
	(as necessary)"							
	A physician's ord	ler dated 6/20/11						
		ontinue order may						
	consume alcohol	•						
		. Resident may consume						
	two alcoholic bev	verages daily PRN."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

W8QP11 Facility ID:

ID: 000148

If continuation sheet

Page 18 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155526		(X2) MULTIPLE CC A. BUILDING B. WING	00	li i	E SURVEY PLETED /2011	
NAME OF PROVIDER OR SUPPLIER PERSIMMON RIDGE REHABILITATION CENTRE			200 N F	ADDRESS, CITY, STATE, ZIP C PARK ST AND, IN47371	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	The clinical reconstant to consume alcolor 6/17/11. An interview with Director of Oper 12:50 PM, indicated after facility Administrative leabout disciplinar incident. The Rother facility was a summary of this Health Facility Administrative Administrative leabout disciplinary incident.	and for resident A did not tion of a physician's order cholic beverages prior to the the facility Regional cations on 6/24/11 at cated the Activity				